Release
Drugs, The Law & Your Rights

Release's Written Submission to the Health and Social Care Committee:
Drugs Policy Inquiry

Release is the UK's centre of expertise on drugs and drugs law. We have been providing free and confidential specialist advice to the public, and campaigning for the reform of drug policy, since 1967.

EXECUTIVE SUMMARY:

- **Drug-related deaths are at record high levels and drug policy is exacerbating health harms**
- **Evidence-based harm reduction interventions are not widely accessible**
- **Current policy is not sufficiently geared towards treatment and the ongoing criminal justice-led approach is ineffective, inefficient and detrimental to people who use drugs**
- **A high-quality, evidence-based response to drugs would divert people away from the criminal justice system and provide adequately funded and person-focused treatment and harm reduction services**

What is the extent of health harms resulting from drug use?

1. Drug-related deaths – the most egregious form of harm experienced by people who use drugs – are at record high levels across the UK.[1] Of the 3,756 overdose deaths registered in 2017 across England and Wales, 53 per cent involved an opiate (1,985).[2] In Scotland, 87 per cent (815) of the 934 drug-related deaths registered in 2017 reportedly involved "one or more opiates or opioids".[3]

2. The UK's current drug policy exacerbates the health harms experienced people who use drugs (PWUDs). The criminalisation of PWUDs and the fear of detection by law enforcement is a key driver for high-risk drug taking behaviours, including: sharing (and use of) nonsterile injecting equipment[4]; rushed consumption of drugs in unhygienic and unsupervised environments[5] increasing risk of overdose or injury; and pre-loading drugs before entering a venue to avoid detection[6].

3. Dehumanising language, discrimination and stigma towards people who use drugs can be significant barriers to accessing health services, thereby undermining the effectiveness of prevention and drug treatment.[7] Hostile attitudes, particularly towards mothers who have a history of drug use, breeds a reluctance to access treatment due to fear of children being removed from their custody.[8]

What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.

4. According to the United Nations (UNODC), 89 per cent of people who use drugs do not experience a drug use disorder[9]. For the small percentage who become dependent, this is often related to trauma, either experienced in childhood or in adulthood, or to alleviate mental health problems. Other risk factors include "stressful life events" and/or determinates which have been present over prolonged periods of time such as "homelessness or poverty".[10]

How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

5. The Advisory Council on the Misuse of Drugs (ACMD) has identified that childhood experiences can have a significant impact on "the development of substance-related harms" and leads to poorer health and social outcomes in adult life[11], underscoring the significance of primary prevention and trauma-informed care. Release supports a whole-system approach, as outlined by the ACMD, of trauma-informed service and "routine screening for Adverse Childhood Experiences (ACEs) in primary and secondary care".[12] As such, the primary purpose of prevention should focus on reducing problematic use or dependency. Strategies for early intervention also need to prioritise safety by highlighting the risks associated with drug use, alongside information to reduce such risks.

How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

6. Release is concerned that, in the context of reduced funding and a recovery-oriented Drug Strategy, evidence-based harm reduction interventions are not widely accessible for PWUDs, effectively failing to protect people from premature mortality. Public Health England reported that "The majority of opiate misuse deaths in the past five years occurred in those who were not identified as being in and had not recently been in community drug treatment"[13]. Release has serious concerns that one driver behind this is Government policy, significant cuts to treatment budgets and the quality of treatment in the UK, as detailed below.

7. Net expenditure on adult drug and alcohol services has decreased by 19 per cent in real terms between 2014/15 and 2018/19, with further cuts predicted until 2020 when the ring-fenced Public Health Grant for local authorities is due to expire.[14] These cuts are a "false economy"[15] – Public Health England estimates that for every £1 invested in drug treatment there is a £4 social return.[16] An efficient drug policy, which prioritised health, would divert resources away from drug law enforcement and back into drug treatment and harm reduction for PWUDs.

8. By promoting a "recovery agenda" which defined abstinence as the key outcome[17], the Drug Strategy 2017 ignored evidence that Opioid Substitution Therapy (OST) – including long-term OST – is a protective factor against premature mortality[18]. Under this agenda, the effectiveness of OST for people who use opioids is being jeopardised by poor practice, such as sub-optimal dosing and duration[19] or over-supervision. The UK guidelines on clinical management of 'drug misuse and dependence' advises:

> *"More stable service users, who do not have a clinical need for such frequent attendance, can be over-treated or over-supervised. This can have a detrimental effect on their ability to return to, or sustain, a more conventional or stable lifestyle. […] It is important, therefore, that attendance requirements are not arbitrary and that they respect individual circumstances".*[20]

Contrary to clinical guidelines, and often without considering a patient's individual circumstances or clinical needs, OST patients are often made to pick up their OST prescriptions daily and consume their prescription under the supervision of a medical professional. Release has supported a number of clients that have been put onto daily pick-ups and supervised consumption of OST for lengthy periods for no clinical reason; many of these clients experienced detrimental impacts from this, such as having to take time off work or bring their

children to the pharmacy every morning, in order to adhere to their prescription. Previous evidence indicated that supervised consumption of methadone reduced methadone-related deaths in England and Scotland.[21] However, more recent evidence suggests that "a longer period or high frequency of supervision may be less effective in retaining patients in treatment"[22]. Moreover, a recent Cochrane review concluded that there was insufficient evidence that supervised dosing of OST was effective at preventing diversion, reducing opioid use, and retaining people in treatment.[23]

9. Research undertaken by Release found that the amount of take-home naloxone – an inexpensive lifesaving medication that reverses the effects of an opioid overdose – given out in England is wholly insufficient and it is not reaching those who most need it.[i] [24] Given that more than half of the drug poisoning deaths registered in 2017 across England involved an opiate[25], it is crucial that THN is easily accessible and widely available to people likely to experience or witness an opioid overdose.

10. Although Heroin Assisted Treatment (HAT) is supported by the Government, as stated in the Modern Crime Prevention Strategy[26], its availability is extremely limited. There are an estimated forty-six doctors in England licensed to prescribe HAT.[ii] [27] Further, the Home Office estimates that only 280 people are receiving HAT in England. Release is also currently advocating for a number of patients who, despite having been on HAT for over 20 years – many of whom are in employment – have been informed their HAT will be stopped due to policy rather than individual clinical reasons. Studies have consistently found higher adherence to HAT, compared to other forms of OST, as well as reduced use of illicit 'street' heroin, and criminal behaviour, among people for whom other opioid substitutes have not been effective.[28] Release supports the ACMD's recommendation of a national centrally funded HAT programme.[29]

11. Needle and Syringe Programmes (NSPs) are clearly effective at reducing high-risk injecting behaviour and blood-borne virus (BBV) infection among people who inject drugs (PWIDs), thereby reducing the prevalence of BBVs and associated costs[30] to wider society.[31] While Scotland, Wales and Northern Ireland all report to the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) on NSP coverage, England does not. As such, it is not possible to monitor the coverage of this vital harm reduction intervention for PWIDs.

12. Drug Consumption Rooms (DCRs) effectively reduce risk of overdose and BBV infections among PWUDs, public injecting and drug-related litter.[32] Additionally, DCRs facilitate access to treatment and healthcare services for PWUDs, including for marginalised groups that would not otherwise have come into contact with such services. Despite the well-established benefits of DCRs, and in spite of the clear need expressed in Glasgow following a localised HIV outbreak

[i] Only 16 per cent of people who use opiates were given a THN kit in 2017/18 and only 51 per cent of the prisons in England had a THN programme in place.
[ii] Evidence from the Select Committee on Home Affairs, stated: "Of 164 doctors on the Home Office list [i.e. licensed to prescribe HAT], thirty-two had moved away from the address held and could not be traced. Forty-one on the list reported that they did not, in fact, hold a licence. Seventy reported they currently held a licence, of which only forty-six were currently using it to prescribe"

and high incidence of public injecting and drug-related litter[33], the government continues to prevent efforts to implement a DCR in the UK on the grounds of the law.[34] However, many of the legal issues that are raised in relation to DCRs are already managed and tolerated in relation to drug checking[35] and NSPs[36].

13. Equally, it is worrying that drug services are reportedly relying on unpaid volunteers and mutual aid groups to cut costs, at the expense of high-quality and evidence-based treatment provision. The ACMD reported on the inclusion of "recovery-oriented requirements", such as "promotion of mutual aid" being included in many new contracts", as well as an "'over reliance' on volunteers, who seemed to provide the majority of the 'recovery-based' work in some areas".[37] We are particularly concerned about the lack of oversight over treatment agencies referring clients to mutual aid groups without consideration of safeguarding for what can be a vulnerable population. In addition, there are specific issues faced by women and people of colour and services are failing to ensure that the treatment provided meets their specific needs.[38] A recent report found that "only around half of all local authority areas in England (n=74, 49.0%) and five unitary authorities in Wales (22.7% of all authorities in Wales) are home to localised support specifically for women", most of which is single sex groups in generic drug services[39]. Release has heard reports of mixed gender groups where women are expected to discuss their trauma, which has often resulted from sexual abuse including rape; this can be re-traumatising and result in less women wanting to access services.

Is policy is sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government's criminal justice-led approach.

14. While it is clear that current policy is not sufficiently geared towards treatment, it is also increasingly apparent that the pursuit of a criminal justice-led approach is fundamentally flawed. A major problem with the Government's drug policy in that 'success' is measured by the prevalence of drug use rather than drug-related harms – at a time when drug related deaths are at an all-time high, this is shocking indictment of the current strategy.

15. UK drug policy is ineffective, as it fails in its own aim to deter use and to supress the drugs market. The notion that tough sanctions reduce drug use has been debunked by many academics[40], experts[41] and even the Home Office itself. A 2014 Home Office report, which compared the legal framework of 14 countries, concluded that there was not "any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country".[42] Despite evidence that tough sanctions are ineffective at reducing drug use, and that Class A drug use had remained stable over the last decade, the Home Office continues to push the rhetoric that 'drug policy is working, drug use is falling'. Moreover, the Home Office's own evaluation of the 2010 Drug Strategy found that drug law enforcement efforts have 'little impact on the availability of drugs' and describes the market as 'resilient'.[43]

16. The ongoing criminal justice-led approach to drug policy is inefficient, the UK spent an estimated £1.6 billion on drug law enforcement[44] in 2014/15 alone, without any evidence that this

approach was effective. In comparison, the ever shrinking expenditure on adult drug and alcohol treatment in England was £640 million in 2018/19. [45]

17. Lastly, current drug policy is detrimental to PWUDs. The 2010 Drug Strategy evaluation identified many negative consequences of drug law enforcement, including increased violence within the market and the detrimental impact for individuals who come into contact with the criminal justice system.[46] Criminalisation creates a risky environment where if someone is at the scene of an overdose or a crime, and they have used or are in possession of drugs, they are less likely to contact the police.[47] The deleterious effect on health resulting from the criminalisation of PWUDs has been recognised by the United Nations, who have recommended that Member States' review and repeal "punitive laws that have been proven to have negative health outcomes and that counter established public health evidence"[48].

What would a high-quality, evidence-based response to drugs look like?

18. To be clear, a high-quality, evidence-based response to drugs cannot be achieve under the current drug policy. The evidence we have highlighted above demonstrates that the ongoing criminalisation of PWUDs is ineffective, inefficient, and detrimental. Please refer to paragraphs 22 – 25 below, which outline the international evidence in favour of decriminalising personal use offences.

19. What we are currently witnessing in the UK is police leadership on the issue of drug policy, as police diversion schemes are operating in the absence of political leadership on this vital issue. Schemes in Durham and Avon & Somerset constabularies divert people caught in possession of drugs (Durham has extended their programme to include supply offences where the person is dependent on controlled drugs), both schemes have recorded reduce reoffending rates, as well as positive health and social outcomes for those diverted.[49] [50]

20. The most significant obstacle to delivering high-quality and evidence-based drug services is the devastating cuts to drug services across the country. In its review of commissioning, the ACMD rightly concluded that "the quality and effectiveness of drug misuse treatment is being compromised by under-resourcing"[51]. A high-quality, evidence-based response to drugs therefore requires central government to re-invest in, and at the very least mandate, drug services to ensure that they are adequately funded.

21. In our view, high-quality service provision for PWUDS is evidence-based and person-focused, meaning people are treated with the respect and autonomy that they deserve. For example, person-focused OST provision would limit the use of supervised consumption and daily pick-ups, in line with clinical guidelines and recent evidence. Person-focused service provision also puts service user voices at the forefront (by providing adequate resources for service user involvement), integrates harm reduction and low-threshold access to services, and prioritises health over criminal justice outcomes.

What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

22. Release advocates for the ending of criminal sanctions for personal use offences, known as decriminalisation, in recognition that the evidence from other countries demonstrates that better health outcomes can be achieved. Research undertaken by the organisation looked at 25 countries across the globe that had decriminalised personal use and possession of drugs and found ending criminal sanctions for such activities did not lead to an increase in consumption of controlled drugs.[52]

23. The Czech Republic decriminalised possession of all illicit drugs in 2010. One influencing factor was a cost-benefit analysis of Czech drugs legislation in 2002 that was undertaken by the National Drug Commission. After a two-year evaluation research found that penalisation of controlled drugs had: not affected availability; prevalence increased; there were higher rates of initiation of drug use amongst young people; and social costs increased significantly.[53]

24. Portugal abolished criminal sanctions for possession of drugs in 2001; instead people caught in possession are referred to a dissuasion committee to see whether they need help to address their substance use. At the same time the Portuguese government invested heavily in harm reduction initiatives, treatment and prevention, which had a profound effect. It is worth noting that the drug-related death rate in Portugal is 4 per million of the population[54], compared to 70 deaths per million in the UK[55]. Other positive outcomes have included: a decrease in problematic use; a 40% reduction in injecting drug use; increased treatment engagement; and significant falls in HIV and TB transmission rates.[56] In addition there was a 18% decrease in the social costs of drug use in the first 10 years of decriminalisation.[57]

25. The rate of drug-related deaths is 19 per million in the Netherlands, 13 per million in Spain, 4 per million in the Czech Republic, 7 per million in Italy, and 24 per million in Germany.[58] While the lower rates of drug-related deaths in these countries will not necessarily stem from the legal framework, it is nonetheless noteworthy that all of these countries have ended criminal sanctions for drug possession offences under various models of decriminalisation. Arguably, better health outcomes can be achieved when drug dependency is viewed through the lens of public health rather than criminal justice.

RECOMMENDATIONS:

26. **Release would respectfully recommend that the Committee consider the evidence for decriminalisation of personal use offences, including possession, and make a recommendation that the UK government adopt this approach**.
27. **Central government needs to re-invest in, and mandate, drug treatment and harm reduction services, to ensure that they are adequately funded and able to deliver high-quality and evidence-based treatment. This means a person-focused treatment system, which is gender and race appropriate, and delivered in line with national clinical guidelines.**
28. **Harm reduction interventions need to be urgently developed and expanded to protect PWUDs from premature mortality, such as by monitoring NSP coverage in England, scaling up naloxone distribution, securing central funding for HAT, and ceasing efforts to block the introduction of a DCR.**

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